CAPACITY MANAGEMENT PLAN
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<th>Version</th>
<th>Date Issued</th>
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**Main Contact**

Rowena Green  
Divisional General Manager  
Trinity Suite  
North Devon District Hospital  
Raleigh Park  
Barnstaple EX31 4JB  
Lead Director  
Director of Operations  
Tel: Direct Dial - 01271 322406  
Tel: Internal – 2406  
Fax: 01271 349574  
Email: Rowena.green@ndevon.swest.nhs.uk  

**Target Audience**

- All staff  
- Non-Executives  
- PCT  
- SWAST  
- Devon, Cornwall & Isles of Scilly LRF  

**Distribution List**

- TarkaNet  

**Superseded Documents**

Winter Plan 2009/10  

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Contact Details
1. Introduction:

This plan describes the measures Northern Devon Healthcare Trust will take to manage any sudden increases in demand and should be read in conjunction with the Major Incident Plan, the Pandemic Flu Plan, Business Continuity Plan and the Bed Management Policy. It describes the day-to-day operational management of the Trust and the actions and responsibilities of the individual team members on a daily basis and details the process of escalation. In escalation individuals will be allocated specific responsibilities and will be accountable for delivering the specified outcomes.

This plan has been developed to link with the escalation plans of other key organisations, including SWAST, DDoc, Primary Care, Adult Social Care and other provider organisations.

The Trust has a responsibility to the health community to provide a high quality, safe service at all times and this plan will ensure the organisation is well prepared and individuals are clear about their roles and responsibilities. All performance targets must be met, including financial, ED, 18-weeks and cancer targets.

2. Key Risks to the Organisation

1. Unplanned absence of staff due to seasonal flu, swine flu, D&V outbreak
2. Increased demand for services due to higher levels of infection within the health care community
3. Increased demand for emergency care in all specialities
4. Issues relating to delayed discharges and community hospital capacity
5. Cancellation of elective admissions and failure of 18-week performance target
6. Failure to deliver A&E and ambulance handover targets
7. Further problems relating to adverse weather conditions
9. Lack of senior A&E medical staff

3. Leadership:

- The Executive Lead for this plan is Kate Lyons, Director of Operations
- The Operational Lead for this plan Rowena Green, Divisional General Manager – Medicine, ED and Community Hospitals and Deputy Director of Operations
- The Divisional Management teams will have individual responsibilities for the execution of specific areas within the plan
- The Executive lead for the Flu Vaccination Plan is Maureen Bignell, Director of HR

The Director of Operations will report to the Executive Team monthly on delivery against the plan.

Virginia Pearson, Director of Public Health is the Executive lead for the NHS Devon and Kate Maynard is the Locality Director for North Devon.

Contact details can be seen in Appendix 1.
4. **Key elements of the day-to-day operational management**

The following details the normal activities to manage 'business as usual'.

**Duty Management arrangements – Business as Usual:**

The duty management rota covers in-hours and out-of-hours.

Katherine Smith, Deputy General Manager – Medicine, is responsible for co-ordinating the in-hours rota.

Janine Royle, Support Secretary – Medicine, co-ordinates the out-of-hours rota, supported by the Divisional General Managers.

The Executive on-call rota is co-ordinated by Maxene Sweetland, PA to the Director of HR, under the direction of the Executive team.

The operations throughout the day are managed as follows:

The night Clinical Site Manager will send a bedstate to a set distribution list that includes the Executives and all Duty Managers which documents:

- Previous day’s admissions
- Beds available now (using SwiftPlus)
- Further discharges (using SwiftPlus)
- Community beds available now and for the following day (using SwiftPlus)

At 08.30 the Duty Manager meets with the Clinical Site Manager and the Patient Journey Facilitator to plan and take action to manage the day’s activity and a plan to manage the predicted number of emergency admissions.

- **Main daily bed meeting at 13.30pm, held in Trinity Suite between Duty Manager and Clinical Site Manager.**

  *If the Trust is in escalation, the following people will attend the 13:30 bed meeting:*

  **Duty Manager (chair)**
  **Clinical Site Manager**
  **Representative from Medicine, Surgery, Women’s & Children’s and ED (including medics if appropriate)**
  **Patient Journey Facilitator**
  **Therapist Representative**
  **Complex Discharge Co-ordinator every Monday and more frequently as required as per Escalation**
  **Infection Control as required**
  **Pathfinder Operational Manager**
  **SWAST representative**

  The purpose of this meeting is to:

  - Review the current bedstate
  - Review the predicted admissions for the rest of the day and ensure robust plans are in place to manage this level of activity
  - Review the community bed availability and the predicted discharges for the following day. Review the community waiting list and plan and allocate transfers from NDDH to the community hospitals for the next day
Review TCIs for the next day
- Develop a plan to ensure at least the first patient on each list is allocated a bed ready for theatre first thing in the morning
- Staffing
- Any other relevant information for planning for the next day

- At 16.45 hours the in-hours and out-of-hours duty managers meet informally with the Clinical Site Manager to ensure plans are in place for overnight

5. Managing Discharge – Business as Usual:

Managing the discharge process forms part of the day-to-day operational management of the organisation.

One of the Complex Discharge Co-ordinators will be based at NDDH on the following times:
- Monday: 8:30 – 12:30
- Tuesday: 1:30 – 5pm
- Wednesday: - 1:30 – 5pm
- Thursday: 1:30 – 5pm
- Friday: 8:30 – 5pm

and will be responsible for:

1) Reviewing all MAU patients transferred from MAU to an inpatient ward who have been referred by MAU as likely to have complex discharge needs to ensure that any patient with complex discharge needs is highlighted early and appropriate processes are started.
2) Assessing all patients highlighted by the wards as being suitable for transfer to a Community Hospital
3) Reviewing medical outliers as appropriate

All wards within the acute Trust and all community hospitals must maintain an up-to-date Estimated Date of Discharge (EDD) on Swiftplus. The night Clinical Site Manager will be responsible for identifying discharges using Swiftplus in preparation for the 08.30 bed meeting.

Complex patients with Complex Care Team (CCT) case managers will be flagged on the PAS so that AE & wards can alert the case manager on admission, to enable the case manager to co-ordinate the discharge plan. In addition, each CCT will be able to run a report to show a snapshot of their patients who are in NDHT hospitals at that time.

Discharges from community hospitals are predicted a week in advance, utilising Swiftplus and identified on the daily bedstate and as with all discharges, the aim should be for a morning discharge. Patients in NDDH will be allocated a bed in their designated community hospital the day before transfer in order that the discharge summary and TTA's are organised and transport is booked ready for transfer early the following morning. It is the responsibility of the receiving ward in the Community Hospital to inform the transferring ward when a bed is available. The transferring ward should not send a patient until the Community Hospital has confirmed that they are ready to receive the patient. The Complex Discharge Co-ordinators will facilitate this process.

The agreement is that patients will arrive at Community Hospitals by 6:30pm – exceptions to this must be agreed by the Modern Matron.
Learning disability – pre-admission assessment is undertaken by the Liaison nurse for Adults with a Learning Disability to enable timely discharge. The Liaison Nurse accesses Care First 6 to access relevant information on patients with learning disabilities. Care plans and risk assessments are co-written between the Liaison Nurse and NDDH staff. The Liaison Nurse will pick up any emergency admissions during working hours and provide support as necessary. They will also refer onto other agencies if additional support is required. There are plans to flag medical notes to highlight this group of patients to the liaison team.

Community Hospitals - The GPs will continue to have access to the allocated community hospital beds, which will support admission avoidance.

Medical cover will be provided for the allocated number of community hospital beds by the community consultant and associate specialists. All community hospitals have some GP beds where the GPs are responsible for the medical cover. Out of hours, cover is provided by DevonDoctors On Call for both GP and Consultant beds.

Intermediate Care – the Pathfinder team is a single point of contact across north Devon for the Intermediate Care service. The operation of joint agency working across North Devon allows for the co-ordination and review of the intermediate care services throughout the year. This allows for early identification of peaks in activity, in particular geographical locations and the reallocation of services to support increased activity.

Services can be accessed 8.00am-8.00pm, Monday to Friday, and 10.00am-4.00pm over a weekend. The services include intermediate care beds and home-based services. Out-of-hours the Emergency Duty Team operates 365 days a year.

Mental Health – the Crisis team is available 24/7/365 and this team can be accessed for all adult patients with a mental health condition. The Crisis team can put in services for patients with functional illness and can signpost to other services for patients with organic illness.

There is a psychiatric liaison nurse and a dementia liaison nurse who are available via switch Monday to Friday 10-6pm.

Out-of-hours arrangements -
- There is 24 hours community nursing linking with Devon Docs
- The existing Out of Hours Emergency Duty Team operates over the Christmas and New Year holiday period. This service operates 365 days per year and enable 24/7 cover.
- The opening times for the Care Direct Plus are Monday-Friday, 09.00am-4.30pm and then there is emergency duty team cover evenings and weekends, 365 days a year. The opening times for Care Direct services are Monday-Friday, 8.00am-8.00pm, Saturday morning 9.00am-1.00pm but there is no bank holiday or Sunday cover.
- The operation of joint agency complex care teams across Northern Devon allow for increased access to teams (health and social care) supporting people with most complex needs.
- The Pathfinder service in North Devon operates over the Christmas holiday period (with exception of Christmas day and New Years day) This service will be available with reduced working hours on 28th December (bank holiday)

NHS / Social Care Joint arrangements
The joint management arrangements in place in North Devon across Health and Social care allow quick resolution of issues in relation to access and authorisation of care packages. Cluster managers manage both health and social care services and are able to authorise packages on a timely basis.

Complex discharge co-ordinators attend the multi disciplinary/agency complex care team weekly core group meetings to promote effective discharge for complex patients. Community Matrons and specialist community teams actively “pull” patients out of acute settings where possible.

GP Practices are starting to identify patients at risk of frequent readmission and working with Complex Care Teams to case manage them. Information on case managers and individual contingency plans are shared with SWAST and DevonDoctors.

Holiday arrangements are as above, however Care Direct Plus will provide enhanced access as working hours are improved from previous year’s arrangements.

Bed service capacity and staffing rotas and contacts are available to local teams. These are accessible to joint managers to enable best use of resources and to identify pressure areas. This extends to some parts of the independent sector.

Local discussions are on-going via North Devon Provider forum to establish effective liaison between local care home providers. This is also supported by the brokerage service, who are in regular contact with local providers to maintain records of service capacity.

There are contingency plans for vulnerable people in the community over the holiday period.

The Pathfinder service is a key contact point for admissions avoidance in North Devon. Rapid Response is a home-based service and can be accessed to avoid hospital admission and redirect patients to an emergency residential/nursing home or diversion to a community hospital.

There are two mechanisms for assessment and discharge planning for NDDH. Care Direct Plus undertakes assessments for discharge plans that are possible via the telephone. Alternatively Pathfinder undertakes assessments for discharges that require a face-to-face assessment. Community hospitals can also access the Care Direct Plus service and local complex care teams for support with discharging patients with more complex needs. These work office hours, however their effectiveness and any delays that occur over the holiday season are routinely reviewed and managed locally to minimise delays.
6. Escalation

During winter there would be planned additional beds, however these would be funded for a period of time only and would not be available during escalation at other times.

The planned additional beds are:

- 7 beds on Capener (October – March)
- 17 beds on Glossop (Jan – Mar)
- 4 beds in South Molton (Jan – Feb)
- 4 beds on Willow (Jan – Feb)
- 4 beds in Holsworthy (Jan – Feb)

Outside of these planned increases in bed numbers, where the staffing is also planned, any increases in bed numbers must be in agreement with the Duty Manager and Director of Operations or Duty Exec as opening these beds outside of the planned period will incur agency costs.

In exceptional circumstances, day surgery may be staffed overnight to provide a ward area for hand picked patients likely to go the following day. Again, this must only be initiated after agreement with the General Manager for Theatres, the General Manager for Surgery and the Director of Operations/Duty Exec.

The following will need action prior to the opening of any additional beds (excluding additional winter pressure beds):

- Explain the exceptional circumstances that require extra beds to the on-call Director
- Check that all Physicians have conducted a ward round in the last 12 hours
- Have all outliers been reviewed? Is there anything that could help earlier discharge of these patients? Could any go to community hospitals?
- Identify, using Swiftplus, how many discharges there will be over the next two days. This will help to identify how many extra beds may be required and for how long

**ALERT**

Details of NDHT’s operational status will be recorded on the daily bed status which will be distributed internally and externally.

If the status changes during the day, the alert will be sent to the following people:

- Out-of-hours Executive Director on-call via Switchboard
- SWAST, who can be contacted on 01392 261621 and ask for the Duty Manager
- DDOC Duty Manager on 01392 823636. The DDOC duty manager has the IT capability to contact and alert all GP practices in our area.
- Adult and Community Services via the Cluster Managers, or alternatively Debbie Sanders, Pathfinder Team, Telephone 01271 247126

7. Managing Patient Flow – Business as Usual

- The admissions lounge, situated on level 4, is open each morning to receive all patients for elective theatre (excluding Gynaecology) – they will admit and prepare patients so beds do not need to be free until late in the morning.

- Infection control issues are of paramount importance. So that all infectious conditions, including Norovirus, MRSA and c.Diff, can be managed appropriately it
is important that Infection Control are informed about all cases of potential infections. The Infection Control Team will state which beds / bays / wards are closed to admission and discharges. Out of hours the Consultant Medical Microbiologist will have this responsibility. Infection control advice must always be sought regarding any patient movements to, from or within these closed areas. It is anticipated that the relaunch of the ‘Clean your hands’ campaign this winter will improve our management of C.diff/Norovirus.

8. On-call arrangements – Business as Usual

There is a Clinical Site Manager on Duty on site 24 hours a day seven days a week.

There is a Duty Manager on call 24 hours a day seven days a week. During weekday working hours the Duty Manager is based on site. Out of hours and at weekends they are on call and contacted by switchboard. They will be expected to come on site as required.

There is an Executive on Call 24 hours a day seven days a week. During weekday working hours the Duty Executive is based on site. Out of hours and at weekends they are on call and contacted by switchboard. They will come on site as required and in the event of a Major Incident.

There is robust on-call cover for all specialities across the organisation available via switchboard.

9. Staffing – Business as Usual

The following actions will be taken to minimise the impact of any staff shortages:

- NHSP are being contacted to advise what actions they are taking to increase NHSP and agency staff availability.
- NDHCT has a nurse pool which is used to cover short-term, last-minute absence. When fully established, there is one trained and one HCA available for the day, and two trained and one HCA available for the night. The nurse pool provides cover 24/7 across both the acute and community hospitals.
- Trust recruitment is currently on track – with limited vacancies. Services are rostering staff, managing annual and study leave to ensure maximum coverage of staff over the peak winter months, including Christmas and New Year.
- There is a Ward Workload Assessment Tool that allows wards to determine the workload and the staffing to identify what additional resources they need or can spare to manage the workload safely. This has a green, amber, red scoring system.

Staffing - Escalation

- In escalation deferral of non-mandatory study leave for all staff will be implemented.
- All departments/clinical areas maintain staff availability/contact lists so that in the event of unprecedented activity, staff will be called in.
- Medical students will be offered the opportunity to work as healthcare assistants if additional staff are required and as per the Pandemic flu plan, some non-clinical staff are being prepared to work in a clinical environment.
- Senior Nursing staff (including specialist nurses and managers with nursing backgrounds) may be pulled into rostered practice if required.
- While it is a last resort to cancel operations, any cancellation of elective surgery may free up recovery staff who can then support critical care, after a period of training which is underway.
• Any other elective activity, including Outpatients, may be curtailed as required, thereby releasing staff.

The management of significant staffing shortages is addressed in the Pandemic Flu Plan.

10. Service Specific Plans – Escalation

Respiratory:
Glossop ward is the respiratory ward within the Acute Trust and has been identified as the Flu ward. The ward can take additional acute respiratory patients as identified in the Pandemic Flu Plan. Additional equipment is available for non-invasive respiratory support. Community respiratory services will be expected to work differently to support the acute patients.

Acute Medicine:
In addition to the normal escalation plans a number of initiatives are under way for acute medicine which will help with capacity through the winter:

• Management of medical outliers: –
  o Plans for additional beds for winter are being developed in line with other resource requirements to increase capacity in Medicine and community hospitals.
  o If medical outliers exceed 15 over a weekend, the Physician on Call will be asked to review outliers identified as possible for discharge during an additional 4 hour session on the Sunday.
  o The Complex Discharge Co-ordinators will be responsible for the accurate recording and updating of the medical outliers report.

The Physicians and Ward Managers will be responsible for identifying medical patients who fit the criteria for outlying. Please refer to the Bed Management Policy. It is expected that on a daily basis the medical and nursing teams identify at least 2 patients fit to outlie.

The Physicians have linked surgical wards as follows: -

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<th>Physician</th>
<th>Specialty</th>
<th>Ward</th>
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<tr>
<td>Dr Davis/Dr Moran</td>
<td>Gastroenterology</td>
<td>Fortescue</td>
</tr>
<tr>
<td>Dr Lewin</td>
<td>Diabetes/Gen Med</td>
<td>KGV &amp; Lundy/Roborough</td>
</tr>
<tr>
<td>Dr Moody/Dr Hands</td>
<td>Respiratory</td>
<td>Capener</td>
</tr>
<tr>
<td>Dr Dent</td>
<td>Care of the Elderly/Stroke</td>
<td>Petter</td>
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  o Where possible, patients will be outlied from their Consultant wards to their linked wards in order to maintain continuity of care and prevent unnecessary handovers
  o If a patient from Glossop, under Alison Moody, is outlied to Fortescue they will remain under Dr Moody unless the Respiratory team say that the patient can transfer to the link consultant (in this case Dr Moran/Dr Davis). The transferring ward should clearly indicate in the notes which consultant the patient is to be under. **It is the responsibility of the receiving ward to update PAS with any transfer of consultant.**
  o If a patient is outlied to a Surgical/Orthopaedic/Petter ward directly from MAU the patient will be admitted under the Physician responsible for that linked ward, i.e. if a patient is admitted to Capener directly from MAU, they will be under Dr Moody/Dr Hands care. **It is the receiving ward’s**
responsibility to update PAS with the change of consultant. Particular care should be taken when the Physician of the Day (PoD) is not an Acute Physician to ensure that the patient is recorded under the link consultant rather than the PoD. The Acute Physicians, Dr Alastair Watt and Dr Ashref Tawil, do not have inpatients. Therefore, under no circumstances, can medical outliers be under these consultants.

The physicians are expected to manage within their medical bed complement. In order to ensure the Division utilises the Acute and community capacity efficiently and effectively, during times of increased pressure, daily discharges/transfers must be identified. During these peaks of activity the Senior Clinician (the Physician) must visit their medical wards daily first thing in the morning and undertake a “virtual ward round” with their teams in order that early senior decisions can be made around transfer/discharge.

The Medical Divisional team will review the emergency activity daily and will internally escalate within the Division when there are: -

- Exceptionally high emergency admissions (more than 30 in 24 hours) or
- Consistently high emergency admissions (more than 25 each 24 hours for 3 days)
- The community waiting list has more than 10 patients ready for transfer and there are no discharges predicted from the community hospitals for the next 3 days

Closing to emergency admissions would be considered as a major serious untoward incident and attract national press interest. At this stage in the escalation process an internal incident would have been called in order to prevent closing but if all else fails and the organisation was unable to safely manage additional emergency admissions, there would need to be a discussion between the Chief Executive and the SHA.

It is a Chief Executive decision to close to emergency admissions and this decision should not be taken without the on-call Executive Director, Duty Manager and on-call A&E, Medical and Surgical Consultants being on site to assess the situation first hand.

During hours, the decision to close will be for the Chief Executive, in consultation with the Director of Operations and the Medical Director. Out of hours, the Executive Director on call should make attempts to contact the Chief Executive and Medical Director but, in the event that they are not available, the on-call Director will be required to make a decision.

For Paediatric bed pressures – please see separate escalation plan.

The Trust will comply with the Pan-South West Policy on responding to Emergency Care Pressures when it is agreed.

Discharge Lounge: there is currently no suitable area that can be used as a fully functional discharge lounge. During periods where there are peaks in demand, wards will be asked to used appropriate areas to ‘sit out’ their discharged patients to allow for the influx of new admissions.

Other Medical Services:
• **Acute Stroke Unit** – the Division will continue to oversee the optimal Stroke service, ensuring patients presenting with a new stroke are admitted directly to the Acute Stroke Unit and spend 90% of their stay within Stroke services.

• **Cardiology**: Cardioversions will continue to be managed on a day case basis and close liaison will be maintained with the RD&E and Derriford to ensure minimal delays in cardiac investigations and surgery.

• **Critical care** – Plans have been put in place to increase the Critical Care capacity in line with the return to the Strategic Health Authority on the 21st August 2009 as per the Pandemic Flu Critical Care Capacity Surge Plan.

**Other Surgical Services**

• Surgical capacity remains the same. The Surgical Division plans to achieve the contracted elective activity and does not have plans to reduce bed capacity over the Winter period.

• Elective admissions will be reviewed and any decisions to cancel will be made in advance as per the Escalation Plan. These actions should reduce last minute cancellation of elective surgery. All decisions to cancel will be made by the Director of Operations or the Executive on call and all actions will have been taken to avoid cancellation.

• For all the main specialities NDDH track elective activity and referrals on a weekly basis to manage demand and referral to treatment times. Therefore the Trust will be able to provide robust data concerning potential breaches of national/local targets.

**Women’s & Children’s Services**

• **Gynaecology** – Suitable patients will be outlined from the gynaecology ward to maternity wards additional capacity is required, such as early pregnancy patients. Elective admissions will be reviewed and decisions to cancel will be made in advance to avoid last minute cancellations.

  The Gynaecology ward at NDHCT closes at weekends and any patients are transferred to a surgical bed. The Trust’s Escalation plan identifies the potential requirement to keep this clinical area open at weekends. Any decision to increase capacity and opening hours will be made and agreed by the Executive Director on-call. Petter staffing at weekends (who are transferred to KGV if the ward is closed) is minimal and only covers the day.

• **Maternity** – NDHCT has in place robust escalation plans to manage an increase in maternity activity and a plan if it required to close the unit.

• **Paediatrics** – see attached escalation plan

**Diagnostics** - Detailed escalation plans are in place, with a variety of contingencies that can be activated depending on the severity of the situation, to ensure that key Diagnostic services are maintained at all times. The Directorate will work closely with the Trust Operational Management Team in the event of increased activity issues, to ensure that the changing, day to day priorities are fully understood by the Directorate; and its services respond accordingly.

**Allied Health Professionals (AHPs)** – the operational management teams will work closely with all other healthcare professionals to ensure all skills are fully utilised to ensure fast, effective, high quality assessments and discharges.
Community

- Community Hospitals – plans are currently being developed around additional capacity in the community hospitals, however there is continual on-going work to reduce lengths of stay to prevent the need to increase the beds.

- Intermediate Care – During unexpected rises in activity non-essential services are put on hold to continue the essential aspects of the service.

Out-of-hours the Emergency Duty Team operates 365 days a year.

11. Ambulance Liaison – Business as Usual

The Trust has established robust relationships with both the Ambulance Trusts and the Out of Hours GP service. Daily contact will be maintained with the local station to ensure there is clear understanding of the bed situation and to ensure their ongoing contribution to the escalation plan.

A SWAST representative will be required to attend 13.30pm bed meetings as required during escalation.

Daily ambulance handover delay data will be reviewed daily as ‘business as usual’ and delays over 15 minutes will be investigated.

Ambulance handover breaches will be monitored and are included as part of the escalation plan.

12. Joint Agency Working – Business as Usual

As an integrated Trust the Acute Divisions work closely with the community to ensure best use of all community services.

In order for the organisation to plan ahead and continue to deliver fast, effective care, a planning meeting is held on Fridays at 12.00 noon on level 5. The agenda for this meeting includes:

- Predicted discharges identified on Swiftplus for the following week across both the Acute and Community hospitals
- Medical and nurse staffing for the weekend and any exceptions going in to the next week
- Elective TCIs by day, by speciality including Endoscopy, for the following week
- Any other potential issues

The Trust has a robust mechanism of alerting GP practices and out-of-hours services to increasing levels of emergency activity.

13. Communication – Business as Usual

Communication services are provided 5 days a week. The contact telephone number is 01271 311575. Out of hours contact is provided by the on call executive, who can be contacted through Duty Manager and switchboard.

If all the Communications staff are unavailable due to illness there is cross cover provided by the SHA and PCT. Their contact numbers are available at the back of this plan.
There is a more detailed communications plan in the Pandemic Flu plan 2009.

Staff Communication

- This plan will be cascaded throughout the organisation and will be available on the Trust intranet site.
- Information is cascaded through Heads of Department (HODS) briefings (monthly or as required), Chief Execs Bulletin (weekly) and Staff Express (as required)
- Tarkanet (internal Intranet) is updated daily or as required.
- In the event of escalation messages to staff will be carried by the Public website and would be password protected. This would be set up and managed by the Communications department.
- Consideration will be given to other forms of communication to all staff such as Pay slip inclusions.
- Established links between primary and secondary care and SHA communications departments are in place and consistent messages to members of staff and the general public are given.
- Key services have been consulted in the development of the plan.

Public Communication

- Set aside space on top of the External website for a service updates within Northern Devon HealthCare Trust which can be updated instantly. The Comms team consists of Katherine Allen, Glen Everton and James Rowles. They can update the website from outside the Trust.
- Good working relationships with local media which includes, Radio Devon, Heart Fm and North Devon Journal and North Devon advertiser. Broadcasts can be requested concerning relevant information as necessary. This worked very well last winter with the snow disruption.
- Support and National Campaign that arises for example, Catch it, Bin it, Kill it. This would be through the Website and Local Press.
- Work with the Strategic Health Authority to promote Public Health messages
- Cross-cover from PCT/SHA Communications teams
  Devon Primary Care Trust Communications tel. 01392 267648 (Head of Communications: Nick Pearson)
  Strategic Health Authority Communications tel. 01823 361365 (Media Relations Manager: Gillian Humphrey)
- Signposting to appropriate services via public website

The front page of our website already carries an 'e-flyer', 'Getting the right treatment in Devon', which explains when and how members of the public should apply Self-Care, contact a pharmacist, NHS Direct, an MIU or their GP Surgery, together with opening hours for these. This will continue to be available on the front page and updates specifically relating to swine flu will continue to be added as appropriate.

Communication links with NHS Devon

There will be a telephone conference call between the Trust and the locality director, or her deputy, and Tim Burke every Thursday at 11.15 am. Jacqui Down (NHS Devon) will set up this conference call and a rolling agenda will be agreed. It is planned that the locality team and the Trust will work closely to ensure there is no significant disruption to “business as usual” during peaks of activity.
14. **Infection Control – Business as Usual**

The Northern Devon Healthcare Trust takes a proactive approach to managing infection control issues via the Trust’s infection control team. There are existing policies that cover isolation, Gastrointestinal disease and outbreak management which allows the outbreak control committee to be invoked and decisions taken on the need for ward closure or opening a dedicated isolation ward if that was necessary to control spread.

An Infection Control (IC) team member joins in bed meetings daily if necessary to help inform operational management decisions and the team also have a high profile in all clinical areas.

The IC team report outbreaks of D&V via the norovirus reporting system of the HPA.

Any outbreaks of potentially infectious diarrhoea and/or vomiting are managed via the Infection Control Team and with patient transfers co-ordinated via the daily operational meeting.

See the following policies for further information:

Gastrointestinal Disease Policy

Isolation Policy

Outbreak Policy

15. **Mortuary – Business as Usual**

The mortuary at NDDH has 39 refrigeration and 5 deep freeze spaces. The capacity can increase to 8 by utilising the mobile body racking and external air temperature control can be reduced to 10°C.

The mortuary has in place a contingency plan in which it could double capacity if required and has developed plans for the prompt turnaround of death documentation.

Community Hospitals do not have mortuary facilities and have SLAs with approved Undertakers.

16. **Major incident escalation**

The Trust’s Emergency Preparedness Plan sets out the arrangements for responding to any major incident. It includes a strategic approach to business continuity.

17. **Adverse weather conditions**

The Trust receives Met Office Severe Weather Warnings. In the event of a warning of adverse weather conditions, such as snow leading to closed roads and limited transport facilities the following actions will be taken:

- The Trust would participate in any multi-agency strategic coordination group that was convened.
- Rotas will be managed by the Ward managers in the event of adverse weather conditions to ensure wards and clinical areas are staffed appropriately. Staff who live locally and are able to get to work would be requested to change shifts. Further details are incorporated in the Pandemic Flu plan.
- Staff will be offered the opportunity to stay on site in hospital accommodation and given a voucher for hot meals.
- Staff who are able to work at home will be encouraged to do so.
- Staff who are unable to get to work will be expected to make contact with health services close to their home to offer their services.
- Elective services will be cancelled as appropriate and as detailed in the plan and staff moved to critical areas.
- The daily Sit. Rep. from all services will be adjusted to include information about availability of staff.
- The Daily Operational Meeting will coordinate actions required and will meet more regularly according to the severity of the situation.
## Contact List:

<table>
<thead>
<tr>
<th>Location</th>
<th>Name</th>
<th>Telephone Number</th>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Devon Winter Planning</td>
<td>Dr Virginia Pearson</td>
<td>01392 267671</td>
<td><a href="mailto:Virginia.pearson@nhs.net">Virginia.pearson@nhs.net</a></td>
</tr>
<tr>
<td>Executive Lead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devon Doctors on call</td>
<td>Jane Moxon</td>
<td>01392 823636</td>
<td><a href="mailto:Jane.Moxon@devondoctors.nhs.uk">Jane.Moxon@devondoctors.nhs.uk</a></td>
</tr>
<tr>
<td>NHS Devon Communications</td>
<td>Nick Pearson</td>
<td>01392 207820</td>
<td><a href="mailto:Nick.Pearson@nhs.net">Nick.Pearson@nhs.net</a></td>
</tr>
<tr>
<td>&amp; Corporate Affairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Devon North Devon Locality</td>
<td>Kate Maynard</td>
<td>01769 575151</td>
<td><a href="mailto:Kate.maynard@nhs.net">Kate.maynard@nhs.net</a></td>
</tr>
<tr>
<td>Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Devon Locality Manager</td>
<td>Carol King</td>
<td>01271 324485/</td>
<td><a href="mailto:Carol.King@swast.nhs.uk">Carol.King@swast.nhs.uk</a></td>
</tr>
<tr>
<td>SWAST</td>
<td></td>
<td>324086 / 07977</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>570078</td>
<td></td>
</tr>
<tr>
<td>SWAST Duty Manager Complex</td>
<td>Sue Oliver</td>
<td>07833 397025</td>
<td><a href="mailto:Sue.oliver@ndevon.swest.nhs.uk">Sue.oliver@ndevon.swest.nhs.uk</a></td>
</tr>
<tr>
<td>Discharge Coordinator Complex</td>
<td>Sandra Walsh</td>
<td>077989 380068</td>
<td><a href="mailto:Sandra.walsh@ndevon.swest.nhs.uk">Sandra.walsh@ndevon.swest.nhs.uk</a></td>
</tr>
<tr>
<td>Discharge Coordinator Pathfinder</td>
<td>Debbie Sanders</td>
<td>01271 247126</td>
<td></td>
</tr>
<tr>
<td>Lead Clinician for Medicine</td>
<td>Andrew Davis</td>
<td>contactable via</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>switch / secretary</td>
<td>Nicola Thorne</td>
</tr>
<tr>
<td>Lead Clinician for Surgery</td>
<td>John Taylor</td>
<td>contactable via</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>switch or on bleep 342 / secretary Sonia Woodage</td>
<td></td>
</tr>
<tr>
<td>Lead Clinician for Obs &amp; Gynae</td>
<td>Seumas Eckford</td>
<td>contactable via</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>switch / secretary</td>
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</tbody>
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Appendix 2
Contingency Plan For Managing Bed Pressures or Staff Shortages on Caroline Thorpe

Introduction

In the rare event that Caroline Thorpe ward has to ‘close’ or restrict admissions to the ward for the following reasons:-

1. Unavailability of beds
2. Staff shortages
3. High dependency of patients

It is essential that all potential solutions have been exhausted.

Closure of the ward has major implications for all emergency patients as well as in-patients.

The decision to close would be taken by Directorate Managers, Consultant on-call, Nurse co-ordinating the ward and the Clinical Site Managers (CSM), with the Executive Director on-call after clinical assessment of the ward has been carried out and discharges made.
## Appendix 3 - INPATIENT ESCALATION TRIGGERS

<table>
<thead>
<tr>
<th>Escalation Level</th>
<th>Status</th>
<th>Action</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Operational Status</td>
<td>&gt;15 beds</td>
<td>Continue on-going management of inpatients. Maintain lines of communication with Clinical Site Manager (CSM)</td>
<td>Ward Managers CSM</td>
</tr>
<tr>
<td>Routine Operational Status</td>
<td>&lt; 5 outliers</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td>Amber</td>
<td>5 &lt; outliers &lt; 15</td>
<td>Complex discharge coordinators review all outliers and escalate to consultant responsible and Service Manager. (Phone numbers available from Annie Florey)</td>
<td>Complex Discharge Coordinators</td>
</tr>
<tr>
<td>Amber</td>
<td>8 &lt; beds available at 08:30 &lt; 16</td>
<td>Identify all potential discharges and expedite early discharge using Swiftplus information, Review medical outliers and ensure they have been seen by the medical teams and have robust medical management plans that have been initiated, Utilise all available community beds, Alert and update the Pathfinder team, Alert pharmacy to prioritise discharge TTAs (highlight names to pharmacy)</td>
<td>CSM, Complex Discharge Coordinators, Complex Discharge Coordinators</td>
</tr>
<tr>
<td>Amber</td>
<td>More than 10 GP referrals to Nigel (MAU Clinic) before midday</td>
<td>Speak to SWAST to see if there are options to influence the admissions times, Actively try to bring the patients in the following morning if patients are unlikely to arrive prior to 4pm, Review need to pull in extra medical staff to see patients (likely to require diagnostics as well)</td>
<td>Duty Manager, Nigel, Duty Manager/CSM</td>
</tr>
<tr>
<td>Amber</td>
<td>Recovery blocking up</td>
<td>Recovery staff alert CSM – General Manager for Surgery or Women’s and Children’s (as appropriate) or the Service Managers to be consulted before surgery is cancelled. The decision to cancel surgery must be cleared by the</td>
<td>CSM / Duty Manager, Service Managers</td>
</tr>
<tr>
<td>Escalation Level</td>
<td>Status</td>
<td>Action</td>
<td>By whom</td>
</tr>
<tr>
<td>------------------</td>
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</table>
| Amber            | Exceptionally high emergency admissions (more than 30 in 24 hours) | ➢ Senior Clinician (the Physician) must visit their medical wards daily first thing in the morning and undertake a “virtual ward round” with their teams in order that early senior decisions can be made around transfer / discharge.  
➢ Consider bringing in the second Complex Discharge Co-ordinator on site to help review patients who have been identified as having complex discharge needs  
➢ Wards to highlight 2 patients suitable to outlie and include the consultant who should be responsible for the patient | Individual Clinicians |
| Amber            | Consistently high emergency admissions (more than 25 each 24 hours for 3 days) | As above | |
| Amber            | The community waiting list has more than 10 patients ready for discharge and there are no discharges predicted from the community hospitals for the next 3 days | ➢ Request Complex Discharge Co-ordinators to escalate delay issues  
➢ Call in Pathfinder Operational Manager and CCT Managers to highlight options to release pressure in the system  
➢ Consider spot purchase of respite/intermediate care beds  
➢ Ensure all patients looking at placement have deadlines by when they must have chosen their preferred placement and ensure interim placements are discussed | Complex Discharge Co-ordinators |
| Amber            | Due to infection risk there is: Single closed bay on single ward at NDDH or Bideford | ➢ See Outbreak Escalation plan | |

21
<table>
<thead>
<tr>
<th>Escalation Level</th>
<th>Status</th>
<th>Action</th>
<th>By whom</th>
</tr>
</thead>
</table>
| Red              | Single closed ward (or closure of any one of following community hospitals Torrington, Holsworthy, South Molton, Ilfracombe) | - As above plus:  
- Open a discharge lounge  
- Alert all consultant teams across the specialties  
- Check bed availability in neighbouring Trusts  
- Alert Health and Social Care Cluster Managers via Switch  
- Alert pharmacy to prioritise specific TTAs  
- Alert Physicians to review outliers earlier in the ward rounds (after review of any patients where the nurses have raised that immediate attention is needed) | CSM / Duty Manager  
Service Managers  
CSM  
CSM  
CSM |
| Red              | Beds available < 8 at 08:30 | - As above plus  
- Review all surgery next day and agree with the clinicians which patients can safely be cancelled if absolutely necessary. Patients may only be cancelled by agreement with Director of Operations (in hours) and Duty Exec (out of hours)  
- Consideration will be given to the need to put additional doctors on shift out-of-hours. This decision will be made with the on-call Consultants for the specialities.  
- Consider options to put up extra beds as per the capacity management plan with appropriate approval | Surgeon on Call / Service Managers  
Clinical Lead for Medicine / Surgery / Service Managers  
Duty Manager / CSM / Director of Ops or Duty Exec |
| Red              | Beds available <8 at 1:30 | - As above plus  
- See outbreak escalation plan | |
<table>
<thead>
<tr>
<th>Escalation Level</th>
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<th>Action</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Ilfracombe) and 1 bay on another ward in any other hospital</td>
<td></td>
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## EMERGENCY DEPARTMENT ESCALATION TRIGGERS

<table>
<thead>
<tr>
<th>Escalation Level</th>
<th>Status</th>
<th>Action</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Operational</strong></td>
<td>Routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A minimum of 65% of patients are being seen and treated within two hours.</td>
<td>Continue on-going management of department. Maintain lines of communication with Clinical Site Manager (CSM)</td>
<td>ED Co-ordinator ED Board Co-ordinator CSM</td>
</tr>
<tr>
<td></td>
<td>98% of patients are being seen and treated within four hours.</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td><strong>1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Operational</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                   | The Department has an influx of patients of greater than 15 in an hour or greater than 12 patients in each of 2 consecutive hours. | ➢ ED Co-ordinator alerts CSM  
➢ Bed Co-ordinator closely monitors timings for each patient  
➢ Senior doctor and triage nurse ‘see and treat’ the minors stream | As above Senior doctor in department |
| **2**             |        |        |         |
| **Operational**  |        |        |         |
| **Status**       |        |        |         |
|                   | Resus has more than 2 patients and are expecting more. | ➢ Alert CSM and request attendance in the department. CSM will be responsible for moving patients out of ED to a bed.  
➢ Alert the duty manager  
➢ Alert POD/SpR and request help in Resus  
➢ Alert Orthopaedic team and request help with minors stream  
➢ In-hours ED consultant to be directing and leading the medical team in ED. Out-of-hours ED consultant to be called into the department  
➢ Fully utilise all the on-call speciality teams | CSM/ ED Co-ordinator/ Duty Manager/ ED Consultant / other on-call specialities |
| **3**             |        |        |         |
| **Operational**  |        |        |         |
| **Status**       |        |        |         |
|                   | Patients waiting longer than 2 hours to be seen by a doctor. | ➢ Alert CSM and request attendance in the department.  
➢ CSM and ED Co-ordinator review all patients in the department and identify speciality help that could be utilised  
➢ ED Co-ordinator and ED Consultant make the decision to divide minors and majors and establish “See and Treat”  
➢ CSM alerts duty manager  
➢ CSM identifies patients for admission and works to move the patients out | CSM/ ED Co-ordinator/ Duty Manager/ ED Consultant / other on-call specialities |
<table>
<thead>
<tr>
<th>Escalation Level</th>
<th>Status</th>
<th>Action</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The total number of patients in the department including waiting to be seen is 25.</td>
<td>As above</td>
<td>CSM/ ED Co-ordinator/ Duty Manager/ ED Consultant / other on-call specialties</td>
</tr>
<tr>
<td>5</td>
<td>An ambulance in the corridor waiting longer than 15 mins</td>
<td>As above</td>
<td>CSM/ ED Co-ordinator/ Duty Manager/ ED Consultant / other on-call specialties</td>
</tr>
<tr>
<td>6</td>
<td>The Department has experienced attendance of greater than 18 patients in an hour or greater than 15 patients in each of 2 consecutive hours.</td>
<td>➢ The duty manager and on-call ED Consultant will be on-site in the department (out of hours there will be a phone call between CSM, A&amp;E and Duty Manager to agree a plan and if required, the Duty Manager will attend A&amp;E)</td>
<td>CSM/ ED Co-ordinator/ Duty Manager/ ED Consultant / other on-call specialties</td>
</tr>
<tr>
<td>7</td>
<td>Resus has more than three patients and have been advised to expect additional patients.</td>
<td>➢ Alerts to go out to SWAST and DDoc ➢ The ED Co-ordinator, Consultant and CSM will go through all the patients in the department and identify majors and minors o The individual specialities will be contacted to see majors patients, including those who were a 999/self-presentation to free up ED staff to see minors o The CSM will have already planned with the duty manager bed availability</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Patients are waiting longer than 3 hours to be seen by a doctor.</td>
<td>➢ The individual specialities will be contacted to see majors patients, including those who were a 999/self-presentation to free up ED staff to see minors o The CSM will have already planned with the duty manager bed availability</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>All majors trolleys full and ambulance on its way in</td>
<td>➢ The duty manager and on-call ED Consultant will be on-site in the department (out of hours there will be a phone call between CSM, A&amp;E and Duty Manager to agree a plan and if required, the Duty Manager will attend A&amp;E)</td>
<td>CSM/ ED Co-ordinator/ Duty Manager/ ED Consultant / other on-call specialties</td>
</tr>
<tr>
<td>10</td>
<td>The total number of patients in the department including waiting to be seen is 35.</td>
<td>This triggers calling an internal incident</td>
<td>Internal incident cascade</td>
</tr>
<tr>
<td>11</td>
<td>Due to patient case mix the department is considered unsafe by the senior clinician.</td>
<td>This triggers calling an internal incident</td>
<td>Internal incident cascade</td>
</tr>
</tbody>
</table>